Toward an Interdependent Conception of the Self: Implications for Canadian Policy Reform

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Abstract: This paper explores three ways of conceptualising the self and the implications of these various conceptions on mental health and the treatment of mental illness. First, I explicate the egocentric view, which is predominantly assumed by Canadian doctors, psychiatrists, and psychologists. Second, I consider an ecocentric approach adopted by some traditional Inuit people. Third, I describe a sociocentric conception, typically upheld by Syrians. I argue that, in order to treat mental disorders in Syrian refugees in Canada more appropriately and effectively, Canadian healthcare providers must avoid imposing the egocentric view and seek to understand their patients' mental health in terms of a sociocentric conception of the self. I make policy recommendations that emerge from an understanding of the sociocentric conception which, if implemented, would help prevent, ameliorate, and remedy mental health difficulties for Syrian refugees.

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Introduction

When we speak of the mentally healthy or mentally ill, we typically refer to the mental wellbeing of an individual, human self. The concept of mental health--and by extension mental disorder--is conceived of according, and as it applies, to the individual. As such, different theories of mental health depend on different understandings of the individual, including the egocentric construal that I will critique. In this paper, I consider Eurocentric assumptions about the individual human being that are implicit in the Diagnostic and Statistical Manual of Mental Disorders (DSM), and consider the import of these assumptions for non-Eurocentric people.[i] To this end, I consider how the DSM-5 reflects Jerome Wakefield's definition of mental disorder as "harmful dysfunction". I show the problems with this view, namely that it does not allow for differing cultural interpretations of the human self. I then explicate Bracken, Giller, and Summerfield's perspective on the dangers of holding non-Eurocentric people to Eurocentric assumptions about the self, and elucidate these dangers through a consideration of a traditional Indigenous conception of the self[ii] and the ways in which it differs from the dominant Canadian colonial view of the human person.[iii]

Syrian refugees in Canada, like many Indigenous people, do not share the egocentric perspective on the self. I recommend that Canadian psychologists and psychiatrists should avoid the limitations of applying the Eurocentric, egocentric concept of the self to individuals from other cultural groups; they should instead seek an alternative for an appropriate understanding and treatment of the mental health of Syrian refugees in Canada. Throughout this paper I critique the egocentric construal of the self in order to suggest that an alternative one – an interdependent conception – may provide a more effective and appropriate perspective on the mental health of individuals from diverse cultural backgrounds. I explore and develop such an alternative view, namely a sociocentric conception of the self; this is the conception to which Syrians typically orient. It is worth emphasizing here that there are numerous understandings of the person that are alternative to the independent construal assumed by many Canadian psychologists and psychiatrists; the sociocentric self is one alternative perspective among many, and this is the one I will ultimately suggest should be given more attention by Canadian public policy related to mental health care. I propose three clusters of policy recommendations that flow from an understanding of the sociocentric conception which, if implemented, would help prevent, ameliorate, and remedy mental health difficulties for Syrian and other refugees.[iv]

I wish to clarify that I am not conflating Syrian and Canadian Indigenous people in this paper; I use the example of Indigenous people to show that Eurocentric approaches to mental healthcare are culturally misinformed and ineffective. I then argue that Syrian refugees comprise another cultural group that typically does not share the Eurocentric conception of self and therefore also suffers culturally misinformed and ineffective mental healthcare services in Canada.

The most recent version of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) used by psychiatrists in North America defines mental disorders as follows:

> A mental disorder is a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behaviour that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress in social, occupational, or other important activities. An expectable or culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental disorder. Socially deviant behaviour (e.g., political, religious, or sexual) and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual, as described above.[v]

Mentally disordered behaviour is thus distinct from merely deviant behaviour. Whereas the deviant person acts outside of a socially constructed norm, the mentally ill person *cannot* fulfill the expected norm. But what determines whether behaviour is distressing? As I will discuss, the conditions which must be met to warrant imputing 'distress' to an individual differ depending on the cultural context in which they manifest themselves. This is what qualifies the DSM-5's claim that culturally expected responses to "common" stressors are not considered disordered behaviour. In Canada for example, it is socially acceptable – and in fact expected – to mourn for some time over the death of one's relative. The loss of a close person is deemed, by our culture, a common stressor. But if intense mourning is prolonged for five years after the death of one's relative, such mourning is no longer considered a normal response to the common stressor of death. Let us imagine that Sara loses her mother. In reaction to this loss, Sara might, for example, experience a lack of desire to socialise, and she might find it unusually difficult to get out of bed, or to clean her living space. But if five years after the death of her mother Sara encounters her mother's presence in her home, has trouble sleeping at night, and faces difficulty performing her daily tasks – in this case, Sara's behaviour has exceeded what is culturally expected of her. Furthermore, her behaviour is clearly distressing to her; she is unable to function as she normally would throughout

the day and she cannot take care of herself. Important to note here is that Sara's inability to take care of herself is viewed, in Canada, as distressing, since it undermines her autonomy as an individual. In a society in which the individual is conceived of in terms of a sole, independently functioning person, the failure to carry out one's daily tasks is distressing.

An Egocentric Construal of Self

Here it is worth pausing to consider what is meant by the term 'individual' in the DSM-5 and in Canadian colonial culture,[vi] which dominates discourse and medical (including psychiatric and psychological) practice. The 'individual' is used to refer to a particular human self. What Markus and Kitayama interchangeably call the independent or egocentric construal,[vii] and what is sometimes also referred to as the biomedical model of the self in medical discourse, is characteristic of many Eurocentric cultures. On this understanding, the self is conceived of as a unified, independent, *individual* entity. By virtue of being a self, one is inherently separate and different from other unique persons. Importantly, the egocentric self holds as a normative standard the autonomous[viii] functioning of the person; this is considered ideal functioning. In the words of Markus and Kitayama, those who privilege an egocentric construal of the self understand the person as "an individual whose behaviour is organised and made meaningful primarily with reference to one's own repertoire of thoughts, feelings, and action."[ix] The self, on this understanding, is only complete as an individual entity. Ideal functioning for an independent self is achieved by that person functioning independently of others. According to Clifford Geertz, the person is: "A bounded, unique, more or less integrated motivational and cognitive universe, a dynamic centre of awareness, emotion, judgment, and action organised into a distinctive whole and set contrastively both against other such wholes and against a social and natural background"

(48). The self is *whole* as an autonomous, unified individual distinct from any external factors, circumstances, or settings.

In his essay, "The Concept of Mental Disorder," Jerome Wakefield puts forth an argument for understanding mental disorder as "harmful dysfunction".[x] Arguably, the DSM-5 definition of mental disorder expresses Wakefield's interpretation of disorder as harmful dysfunction. Wakefield strives to reconcile two opposing ideas of what constitutes mental disorder: on the one hand, a purely scientific approach that views mental disorder as completely reducible to physical lesions in the brain, and on the other a purely normative approach in which mental disorder is deemed merely a social construction. The issue with the former view is that it does not account for the differing cultural views as to which lesions constitute disorder and which do not – it asserts too narrow an interpretation of disorder. The latter view on the other hand is too broad: there are many undesirable traits internal to human beings, but many of these are clearly not disorders. For example, the pain of teething, though undesirable and not valued by society, is nonetheless a natural aspect in the order of human life, and cannot be considered a disorder (376). Moreover, investing cultural value judgments with complete authority to decide what counts as disorder leads to the impossibility of distinguishing between correct and mistaken diagnoses (376-7). It does not account for the cause of disorder, but merely cultural reaction toward it.

Wakefield's approach, then, offers an account of the scientific cause of disorder and at the same time takes into account the importance of cultural milieu. He bridges the gap between these two extremes to provide a framework for understanding mental health in terms of both its scientific and societal implications. Understanding mental disorder in terms of 'harmful dysfunction' achieves this because it requires a biological cause for the dysfunction *and* a negative value claim about that dysfunction. Wakefield explains the term as follows:

> *Dysfunction* is a scientific and factual term based in evolutionary biology that refers to the failure of an internal mechanism to perform a natural function for which it was designed, and *harmful* is a value term referring to the consequences that occur to the person because of the dysfunction and are deemed negative by sociocultural standards.[xi]

On this model, the dysfunction condition describes a situation in which an internal mechanism does not function according to its evolutionarily determined purpose. How do we know what the proper purpose, or function, of an internal mechanism is? Wakefield suggests that the function of a mechanism is found in what it typically does, across the species. For example, we know that the function of fingers is to allow us to grab and hold things because that is what fingers have, observably, evolved to *do.* Interesting to note is that there may indeed be differing cultural views on what exactly the primary function of a given mechanism is. For example, one culture might believe that the function of reproductive organs is to reproduce; another culture might believe their function is to facilitate bodily pleasure. In each case, the organs *do* what the cultures perceive to be their main function; the dispute, then, occurs over what the primary, evolutionarily determined purpose of the organs is. Arguably then, even the dysfunction condition is not a purely scientific phenomenon, but is itself culturally informed.

Even if we do accept the dysfunction condition as accounting for the purely scientific basis of disorder, there remains this second condition of distress or 'harm' that must be met in order to qualify that dysfunction as disordered. What constitutes harm to an individual, Wakefield argues, is dependent on how a particular society understands harmful behaviour. Thus, even if a certain cognitive process fails to perform according to the human evolutionary standard, such dysfunction is not considered mental disorder unless the society in which the individual with the dysfunction lives considers it to be a negative trait – it is only a disorder insofar as it is disvalued by the

culture. For example, hallucinations are not a proper function of the human brain (at least according to the Western understanding of the evolved brain), so they constitute dysfunction. But to constitute mentally *disordered* behaviour, hallucinations must also violate culturally approved values.[xii]

The concept of harmful dysfunction is a useful one – but it is important to note that Wakefield (like the DSM) frames this concept in terms of the *individual* person. What is missing from this account of mental disorder is what it means to be an individual. Wakefield's incorporation of cultural influence into the definition of mental disorder is a good step toward accepting different ways of knowing, and toward mitigating a colonial domination over "truth" in the area of mental health. Wakefield's account allows for different, equally true interpretations of what constitutes harm in disorder, across different cultures. To hold all individuals to one definition of harm is to assert a narrow ignorance of other, differing value-judgments – it is to hold all people, regardless of background, to one single value standard, and thus to erase any other truths that societies may hold. But Wakefield's account could be improved. The concept of harmful dysfunction is useful – but it is important to note that Wakefield (like the DSM-5) frames this concept in terms of the *individual* person. What is missing from this account of mental disorder is a theory of what it means to be an individual. Wakefield offers a good working concept of what mental disorder is, on a conceptual level. But in order to understand the individual's experience of mental disorder (and subsequently to treat it), I suggest we must assess what the human self is [culturally] perceived to be. Wakefield's account, like that of the DSM-5, although it does account for differing cultural ideas about harm, does not account for differing cultural ideas of the 'self' afflicted by dysfunction; it assumes a strictly Eurocentric narrative of the human person. I will explain this problem further in what follows.

To return to the DSM-5 definition of mental disorder, "Conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction *in the individual.*"[xiii] This qualification highlights the key role that the "individual" plays in the DSM-5's conception of mental health. On this definition, mental disorder is necessarily an *individual* experience. It is constituted by biological, psychological, and developmental functions (or lack thereof) in the individual person. Although the condition of distress, or harm to the person, might manifest in social situations, this distress is only experienced secondarily; social and other distresses are endured precisely because of the prior condition of dysfunction in the individual. To revisit Sara's case: if Sara's brain does not process visual images in the same way as is [what medical professionals perceive to be] typical of the presently evolved human species, then she is deemed to have a dysfunction in her brain. This dysfunction in Sara's brain, on a purely biomedical individual level, is a pre-condition for societal reaction to that dysfunction. One given culture might accept Sara's dysfunction as ordinary, or even desirable – for example, some cultures understand hallucinations to be a mystical gift. In such a cultural context, Sara will not be distressed as a result of having the dysfunction. Another culture, however, might ostracize Sara for her hallucinations, causing her harm; this latter case would constitute mental disorder, for Sara.

The label of "mental disorder" thus relies on cultural reactions to an individual person's functioning. On this account, the human self is clearly conceived of as an individual who is ontologically prior to the society in which that one takes part. Sara is an individual, and her society is external to her as an individual. The DSM-5 assumes this particular idea of the human self, and mental disorder according to the DSM-5 can only be understood in terms of this idea. It is important to point out, however, that this is a particularly Eurocentric conception of the self.

Just as we saw that the notion of harm might differ among cultures, so the concept of the self is understood differently according to different cultural groups. While in Eurocentric culture the self is predominantly understood as an autonomous, unified entity, other cultures adopt a much less egocentric understanding of the human being. The DSM-5 reflects a Eurocentric approach to the human being, and holding such assumptions about the individual might be effective in certain, Eurocentric contexts – such as the diagnosis and treatment of individuals raised with Eurocentric values. For example, for a Canadian who conceives of herself to be an autonomous individual being (at least at optimal functioning) the framework of the DSM may be useful because it allows the medical practitioner to assess her functioning according to an accurate and appropriate measurement.[xiv] But holding non-Westerners accountable to a Eurocentric conception of the self can be dangerous and harmful.

An Ecocentric Conception of Self

In their paper, "Psychological Responses to War and Atrocity: The Limitations of Current Concepts," Bracken, Giller, and Summerfield explore the dangers of assuming a biomedical understanding of the self, for the field of mental health. While their paper focuses on the implications of such an approach for treating individuals affected by PTSD, their observations arguably hold for all types of mental disorders. In what follows, I will explicate the consequences of the DSM-5's assumptions about the 'individual' that Bracken, Giller, and Summerfield point out, then I will consider their observations about the import of the DSM-5's biases for PTSD. I will consider the implications of this particularly for Syrian refugees in Canada.[xv]

The focus of psychiatry and psychology in the West is the individual.[xvi] Thus, treating mental illness typically involves a professional-client relationship. The individual is treated by the

professional as an isolated entity, separate from family, community, or even political involvement – attachments which in many communities are seen as integral to the identity of the person. The person is seen through a biomedical lens, so the mental disorders that one undergoes are likewise conceptualised in terms of a biomedical framework; the social, political, or economic context in which that mental disorder develops is disregarded as irrelevant to the dysfunction internal to the individual.[xvii]

Troublingly, Eurocentric conceptions of mental disorder as framed by this individual narrative are assumed to be universally applicable. That is, the observation of particular patterns or experiences of mental disorder in the West are assumed to be true of all individuals.[xviii] Bracken *et al*. observe that the assumption that all people conceive of the 'individual' self in the same way is a deeply problematic one, because it leads to the assumption that different people will have generally the same experiences with mental disorder. This is a clearly problematic assumption because it undermines the varieties of culturally particular experiences that each person in a multicultural society undergoes. Assuming a particular narrative of the individual and the framing of individual experience erases the important differences in ways of experiencing that people have. Besides the obvious insensitivity and reductionism contained in such an approach, it holds dangerous implications for treatment of mental disorder in non-Eurocentric individuals. If we assume that all individuals experience mental disorder in the same way, then we will attempt to address those experiences unanimously – using the same method for healing. In various parts of the world, healing takes place in ways other than the client-professional relationship typical of Eurocentric society.[xix] Therefore, it is clear that trying to treat these individuals according to Eurocentric methods may be fruitless at best, and harmful at worst.

This problem is clear in the treatment of mental disorders in Indigenous communities, such as the Inuit in the Canadian context. Traditionally, Inuit people do not share an understanding of the person as an egocentric "I". Rather, they conceive of the human self as a harmonious relation between the person, one's community, the land on which one lives, and the animals from which one is nourished.[xx] The individual, then, is not reduced to a sole, autonomous being, but rather a connection of the four aforementioned aspects of the self. On this view, the typical evolved functions of a human being are not found strictly internally. It may be the case that a physiological dysfunction is internal to the person – for example, a lesion in the brain. However, it is equally possible that a factor external to the person fails to perform its function in the self, and in this way the self suffers a dysfunction. If, for example, one loses one's connection to animals and the land as a result of forced displacement into a less open landscape, then one loses an important aspect of one's identity. In such a case, the self is ruptured; it experiences the loss of the function that animals are meant to provide it. When the self is incomplete because an essential aspect of it is denied or missing, then one experiences dysfunction. In case one's cultural beliefs disvalue that loss or dysfunction, then a mental disorder results. The biomedical view is unlikely to give proper consideration to the implications for an individual's sense of self from experience of relocation or alienation from animals and nature. Wakefield argued that the purpose of an individual's internal process is determined by its observable function. In this case, traditional Inuit observe that the function of the human being is ecocentric, rather than egocentric. This observation about human nature should be considered just as legitimate as the one put forth by dominant Eurocentric thought.

In their paper, "Locating the Ecocentric Self: Inuit Conceptions of Mental Health and Illness," Kirmayer, Fletcher, and Watt explore various examples of mentally disordered Inuit

persons in Canada. They tell the story of a woman who experienced depression because she did not have access to seal meat – an important staple food for Inuit, which constitutes part of the person's connection to animals.[xxi] This woman was experiencing distress in her daily life – she suffered from headaches and nausea and her mood was unpleasant – and this distress stemmed from a lack of functioning in one area of her self. In order to be restored to ordinary mental health, the woman declared that she needed to consume seal meat for a few days. This is a common occurrence in many Inuit.[xxii] The dysfunction in the woman occurred on the level of her connection with animals, and the harm was experienced by her as a person – both physically, and in terms of her culturally developed views on the value of seal meat to the self.

In another case, an Inuit man, Taamusi Qumaq, explains that whenever he is sick he needs his family present with him, as well as his diet of marine mammals and plants.[xxiii] Taamusi Qumaq is not benefited by the medicine that doctors and nurses prescribe him for his illnesses. To return to normal functioning, the dysfunctions that occur in the areas of community/family connection and animal connection must be healed. The Inuit way of conceiving of the self differs from the dominant Canadian colonial narrative of the individual; thus the Inuit experience of mental disorder caused by a dysfunction in the self will likewise differ from the experience of the Eurocentric individual. If we are to treat Inuit mental disorders, we must approach them with an understanding of the context in which that disorder arises – pertaining both to the person and to that one's cultural (including political and economic) background – rather than judge the person's experience through the lens of our own contexts.

To respond effectively to instances of mental disorder, we must broaden our understanding of how mental disorder is characterised as a dysfunction in the "individual". This dysfunction cannot be limited to the strictly biological, psychological, or developmental functioning of the

human being, especially if we wish to treat non-Eurocentric individuals. This point is crucial to consider in the case of refugees seeking mental health care in their new Eurocentric homes. Specifically, Syrian refugees living in Canada, like many Indigenous people, do not hold the same egocentric view of the individual person.[xxiv]

A Sociocentric Conception of Self

An alternative conception of the self should be taken into account in our thinking about, treatment of, and policies regarding the mental health of persons who do not identify with the dominant Canadian colonial tradition of thinking about the self. The interdependent self, which is privileged by many non-Eurocentric cultures, envisions the self not in terms of one's independence from others, but rather by one's connection to them. This is the approach to the self commonly preferred by many Arab cultures, and specifically by many Syrian individuals. The interdependent conception is also referred to as sociocentric, or relational.[xxv] This perspective "insists on the fundamental connectedness of human beings to each other."[xxvi] The sociocentric self is not whole as an autonomous being; rather, one is only whole when one is successfully integrated with those in one's social circle. This is considered healthy functioning of the sociocentric self. Indeed, then, one who holds an interdependent perspective on the self will suffer when one loses one's connection to others, for it is this connection that constitutes a fundamental dimension of one's person. On the interdependent conception, "one's behaviour is determined, contingent on, and to a large extent organised by what the actor perceives to be the thoughts, feelings, and actions of others in the relationship."[xxvii] The person is not radically separate from a given social context; thus that one cannot be understood meaningfully as an isolated individual entity.

Family and community ties are extremely important to Syrian people, and these relationships are given high priority in Syrian life. Thus, a break in one of these ties could be conceived as dysfunction, as we saw was the case with Inuit people. Canadian psychologists and psychiatrists treating Syrians with mental disorder, if they are to be responsive to cultural particularities, should not project Eurocentric values and beliefs onto Syrian people. Professionals working within the framework provided by the DSM-5 for mental disorder would have to reduce a Syrian's experience of mental disorder to a mere biological malfunction that causes that individual harm. This can lead to lack of understanding of the mental health problems being faced by Syrian refugees, and inappropriate treatment stemming from that misunderstanding. If we treat individuals with the aim of having them return to the healthy state of an individual, but their idea of what that healthy state is differs from what they are being prescribed, then treatment might actually cause more harm than good, for it may undermine what it means for that person to be a functioning self in the first place.

Furthermore, working with the biases implicit in the DSM-5 toward a particular understanding of the individual leads to a higher possibility of misidentifying illness. If we conceive of the individual in one particular way, and thus make corresponding assumptions about how individuals will react in certain situations, we may in this totalising perspective lose the lived experience of the subject. Syrian refugees have come from war-torn countries – and often, victims or witnesses of war develop PTSD. But we cannot project the "universal" individual response to certain stressors on every person confronted by that stressor. Firstly, doing so strips the person of that one's own narrative. More pressingly, it can lead to misdiagnoses and a confusion in treatment. Bracken, Giller, and Summerfield write of the experiences of a Ugandan survivor of war and torture; this man, rather than developing PTSD as a result of torture, felt that his time in

prison had been a positive experience since it strengthened his faith.[xxviii] While "universal" symptoms of PTSD are often present in victims of war in other countries, "they seldom dominate the person's account of their suffering."[xxix] The way in which harm is experienced, and the root dysfunction which causes distress, can differ among people, and this is clear in the case of non-Eurocentric individuals. The experience of certain events, such as the war in Syria, do not guarantee a linear narrative response from the "individual" because the framework of experience is different. But even where parts of the response to a stressor are similar or identical, the experience (the cause of dysfunction) is still conceived of according to a different understanding of the individual person than that given in the DSM. Different cultures conceive of mental disorder differently, so we need to take into account differing possibilities of responses in our Canadian community.

Refugees, despite coming from unsafe living conditions that likely produced in them some level of trauma, do not necessarily suffer from mental disorder. Furthermore, the act of migrating to a new country is indeed a stress factor, but it is not on its own a significant contributor to poor mental health.[xxx] What is significant about the migration process, however, takes place once one has arrived in one's new country of refuge. According to the January 2016 report prepared by Agic, McKenzie, Tuck, and Antwi for the Mental Health Commission of Canada, "The way refugees are welcomed into the country, where they live, whether they can work, if they are considered residents, and their access to education, training, and initiatives fostering social inclusion (e.g. language classes and resettlement services) are fundamental factors in promoting mental health."[xxxi] Recalling the interdependent conception of the self that Syrians typically uphold, the self is connected and assimilated into the new social context with others; it is the successful integration of one's self with the mesh of the community that is most desirable and

most indicative of a person's wellbeing. It is imperative to realise, as I will argue below, that Canadians play a pivotal role in helping Syrians achieve this sense of belonging. It is clear, then, that efforts in Canada should be focused on promoting mental health and wellness for refugees by helping them integrate into their new community.

Implications for Canadian Policy

The interdependent conception of the self is context-dependent. That is, since the self is in part determined by others, then it is the context of one's social surroundings that influence the development of one's self. This idea is particularly salient for the situation of refugees who hold an interdependent conception of the self, since the entire social context of a refugee's life is changed when that person arrives at the place of refuge. "Others participate actively and continuously in the definition of the interdependent self."[xxxii] A person's self is not a single, bounded entity that holds over time; it is constantly affected by the relationships in which one is engaged. Therefore, it is crucial to comprehend the essential role that our community members, namely Canadian citizens, play in the development of many newcomers' sense of self. The Canadian context in which Syrian refugees now find themselves contributes to their development and understanding of self. It is in relation to others in Canada that the interdependent person now organizes that one's thoughts, feelings, and actions. The Syrian conception of the self is construed partly according to the strength of the person's relationships with others in that one's new home; thus we need to ensure that these relationships are not detrimental.

This holds important implications for the mental health of Syrian refugees in Canada. If one's wellbeing depends on how successful one is in connecting with others in one's social environment, then a poor connection with others may lead to poorer mental health. Recall the

interdependent person cannot be understood separately from the larger social context; Syrian individuals, however, often feel isolated and excluded from the larger Canadian community that they join. Given the importance of interconnectedness to the Syrian self, it is arguably the case that refugees, when marginalised and ostracised, are led to feel as though they are missing an essential component of themselves. That is, the loss of strong family and community ties can certainly lead to the development of mental disorder for refugees.

Contemporary refugees are very often separated from their family members, which causes a considerable strain on their mental health. Furthermore, many of them do not have a strong command of the English language,[xxxiii] a fact that leads them to feel alienated from the rest of the Canadian community. Although Canada grants refugees many privileges that other states do not,[xxxiv] we are still far from perfect in this area, and it remains the case that refugees are treated by many as a burden on the state and on the community. The sense of exclusion this fosters further harms the Syrian person's conception of self, as it highlights the loss of close-knit relationships with others. In a specific cultural context which is also characterised by an interdependent conception of the self, exclusion is understood as "one's failing at the normative goal of connecting to others... The ability to effectively adjust in the interpersonal domain may form an important basis of self-esteem."[xxxv] One's ability to integrate into the Canadian community is therefore clearly an important determinant of the mental health of Syrian refugees. However, crucially, since others play an active role in the instantiation of one's self, the behaviour of Canadians themselves toward Syrians is an equally important determinant of their mental health. Thus it is crucial that we strive to create an atmosphere of social inclusion for refugees in Canada. On the level of government policy, we should implement culturally sensitive, proactive practices

in order to help Syrians assimilate more effectively, and therefore also to help prevent the development of mental disorder in Syrian refugees from occurring in the first place.

According to Tara Saberpor, "Social exclusion is one of the social determinants of health."[xxxvi] A lack of inclusion is particularly harmful for the interdependent self, and therefore puts the mental health of such a self at risk. Currently, there are several barriers to the inclusion of Syrian refugees in Canada. As Saberpor shows, these involve a lack of linguistically appropriate services, a lack of awareness of Syrian cultural needs, inaccessible care, and a lack of refugee voice in the system of care, among others.

Conceptualizing persons in terms of a sociocentric, interdependent concept of themselves would help with the development of more effective, culturally sensitive, and appropriate public policies in Canada. A better understanding of conceptions of the self other than the biomedical one that dominates Canadian mental health discourse can lead to a better understanding of the particular mental health needs of people from differing cultural backgrounds. Keeping in mind the importance of social inclusion for the interdependent self that Syrians typically uphold, we should implement policies that help alleviate the barriers to social inclusion for Syrian refugees in Canada. The interdependent self thrives on strong connections with others, and these connections are built on trust among people. Refugees often come from a background of experiences that have contributed to a loss of trust in government officials and individuals. In what follows, I outline three core policy recommendations that flow from a more relational conception of the self, and which can help provide reasons for Syrian individuals to trust in a relational way:[xxxvii]

1. Better health services:
    i. *Clearer communication of available health services*: Often, information about the health

services available to refugees is obscure, so refugees and healthcare providers are not clear on what refugees are in fact entitled to.[xxxviii] This means that refugee persons do not take up the services that are available to them, because they are unaware of their entitlement to these services. Moreover, healthcare providers are often hesitant about providing care to refugees, since they are uncertain about the relevant insurance procedures and payment.[xxxix] It is crucial that there be clearly communicated information about health care, easily accessible for refugees. Each provincial government and, when appropriate, municipal governments, should have a designated group of individuals who work on ensuring optimal dissemination of information about healthcare services to refugees and healthcare providers.

ii. *More robust health services*: On a related note, we should offer more robust healthcare to refugees. It is much more conducive to wellness to maintain and promote the conditions necessary for individuals' health to flourish, rather than to respond only to emergency health needs. Instead of focusing funds on treating health problems once they arise, we should invest more in ongoing care to ensure that health problems are prevented. The screening process that refugees undergo upon entry to the country, to determine whether they carry any health risk to Canadians, are not enough and often fail to address crucial health issues.[xl] Indeed, investing in preventative care is a more cost-effective and better use of resources, in the long-term.

2. More effective social services:

i. *Housing*: The availability of adequate housing for refugees and newcomers has been a significant challenge; this issue has been widely reported in the media. For example, being kept in a hotel for months at a time, waiting for housing to become available, does

not foster feelings of inclusion. Accommodations must be organised and available prior to refugees' arrival, in order to avoid such deplorable circumstances. There has been significant recognition of the increasing role of the municipal government in establishing housing for newcomers. Housing is a pressing issue for people with mental health issues and for Indigenous persons as well as for immigrants and refugees. The need is clear for greater funds to be allocated to expanding social housing availability. McKeary, Mays, and Newbold comment that refugees often perceive the place of refuge to be a tenuous one.[xli] Obviously, setting up one's life in what one knows to be a temporary space does not contribute to a sense of home in that space. It would thus be helpful to provide refugees with a stable living environment in which they may, over time, develop a sense of home.

ii. *Employment*: Another service that must be given more attention is the availability of individuals to assist refugees in finding suitable jobs. Unemployment is a major contributor to poor mental health,[xlii] and it makes individuals feel as though they are not contributing to the larger societal whole. For those whose sense of self is not detachable from the societal whole, this problem poses a mental health threat. Navigating the job market in a new country and a foreign language is a significant challenge, and we must assist refugees in the process. Provincial and municipal governments should work together to create outreach programs that offer help to refugees navigating job application processes.

iii. *Linguistically appropriate services*: Social services and health services should be available in Arabic, both to ensure that Syrian refugees feel familiar and comfortable throughout the process, and also that they understand clearly what is being communicated

to them. One factor contributing to the miscommunication of services that I discussed above is the fact that refugees sometimes misunderstand these communications, when they are made in English. Even more pressingly, misunderstandings can lead to incorrect information transfer and in the context of medical appointments, incorrect diagnoses. In cases where the service itself cannot be offered in Arabic, translators should be present. However, it is important that refugees are given the opportunity to establish relationship continuity with their interpreters. Encountering a different translator each time one requires interpretation services is not ideal because it does not give the refugee time to develop trust in the interpreter.[xliii] The need for a consistent professional translator is pressing and should be addressed by provincial and municipal governments. Establishing this would allow refugees to feel more at ease in the presence of their translator (over time), which contributes to their feeling secure throughout their interactions with others.

3. Garner Feedback: Optimal care can only be achieved if those receiving it are given the opportunity to provide feedback on how the process works or fails to work for them. Refugees do not have a say in the system that serves them.[xliv] Allowing refugees to discuss their needs makes it possible for them to feel as though their opinion matters, and as though they are included and valued in the community. We should implement iterative policy evaluations to be undertaken by government officials, in light of the lived experiences of refugees. There must be a feedback loop between all government levels, and between the municipal government and refugees, so that all levels of government are up to date and aware of the efficacy of their programs and actions. Ineffective programs and policies need to be modified and tailored according to the feedback from refugees themselves.

Conclusion

I have argued that the condition of harmful dysfunction for mental disorder is helpful, because it accounts for differing cultural views on what is optimal health and what constitutes harm to the afflicted individual. However, this understanding of mental disorder must be further expanded upon to include differing cultural views on the human self. Treating Syrian refugee mental disorders, especially PTSD, according to the framework provided by the DSM undermines the subjective experience of mental disorder that Syrians may have. While we might believe that we are effectively treating individuals because we are raising them back to what we perceive to be the 'standard of performance determined by evolution', in fact we are causing them more harm since we are stripping them of essential aspects to their whole identity. A concept of mental disorder as harmful dysfunction must take into account culturally sensitive views on what dysfunction in the 'self' entails. Broadening our understanding of the interdependent self in particular will allow us to help Syrian refugees to restore their own sense of self – for effective treatment necessarily begins with competent understanding.

Moreover, gaining a deeper understanding of the relational concept of the self can allow us to help prevent the development of mental disorder in the Syrian refugee population. With this goal of prevention in mind, we should allow the interdependent model to inform Canadian public policy regarding refugees. A relational approach that takes into account the importance of community ties and social inclusion can lead to more effective policies in Canada that contribute to refugee belonging and wellbeing.

Works Cited

Agic, Branka, Kwame McKenzie, Andrew Tuck and Michael Antwi. "Supporting the Mental Health of Refugees to Canada." *The Mental Health Commission of Canada*, Jan. 2016, https://ontario.cmha.ca/wp-content/files/2016/02/Refugee-Mental-Health-backgrounder.pdf. Accessed 23 Dec 2017.

American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders, 5th ed*. American Psychiatric Publishing. 2013.

Beiser, Morton. "After the Door Has Been Opened: The Mental Health of Immigrants and Refugees in Canada". *The International Refugee Crisis* edited by Robinson Vaughan, London: Palgrave Macmillan, 1993, pp. 213-227.

Bracken, Patrick J., *et al*. "Psychological Responses to War and Atrocity: The Limitations of Current Concepts." *Social Science and Medicine*, vol. 40, no. 8, 1995, pp. 1073–1082.

Butler, Martha and Karin Phillips. "Current Issues in Mental Health in Canada." *The Parliamentary Information and Research Service*, 15 Aug. 2013, Publication No. 2013-76-E.

Coulthard, Glen Sean. *Red Skin White Masks: Rejecting the Colonial Politics of Recognition.* University of Minnesota Press, 2014.

Fazel, Mina, Jeremy Wheeler, and John Danesh. "Prevalence of serious mental disorder in 7000 refugees resettled in western countries: a systematic review." *The Lancet*, vol. 365, no. 9467, 2005, pp. 1309-1314.

Geertz, Clifford. "From the native's point of view: On the nature of anthropological understanding." *Meaning in Anthropology*, edited by Keith Basso & Henry Selby, Albuquerque: University of New Mexico Press, pp. 221-237.

Harb, Charles and Peter Smith. "Self-Construals Across Cultures: Beyond Independence-Interdependence." *Journal of Cross-Cultural Psychology*, vol. 39, no. 2, Mar. 2008, pp. 178-197.

Kirmayer, Laurence, Christopher Fletcher, and Robert Watt. "Locating the Ecocentric Self: Inuit Concepts of Mental Health and Illness." *Healing Traditions: The Mental Health of Aboriginal Peoples in Canada*, edited by Laurence Kirmayer and Gail Guthrie Valaskakis. Toronto: UBC Press, 2009, pp. 289-314.

Maisel, Eric R. "The New Definition of a Mental Disorder." *Psychology Today*, 23 Jul. 2013, www.psychologytoday.com/blog/rethinking-psychology/201307/the-new-definition-mental-disorder. Accessed 4 May 2017.

Markus, Hazel R. and Shinobu Kitayama. “Culture and the Self: Implications for Cognition, Emotion, and Motivation.” *Psychological Review*, vol. 9, no. 2, 1991, pp. 224-253.

McKeary, Marie, Christopher Mays, and Bruce Newbold. “Barriers to Care: The Challenges for Canadian Refugees and Their Health Care Providers.” *Journal of Refugee Studies,* vol. 23, no. 4, 2010, pp. 523-545.

Saberpor, Tara. "Refugee and Asylum Seekers in Canada: Barriers to Health Care Services". *Glendon Journal of International Studies*, vol. 9, 2016.

Wakefield, Jerome C. “The Concept of Mental Disorder: On the Boundary Between Biological Facts and Social Values.” *American Psychologist*, vol. 47, no. 3, Mar. 1992, pp. 373–388.

Notes

[i] I am not imputing there is a universal non-Eurocentric view on the self; there are various different conceptions of the self that various different cultures and people uphold. I am using the term non-Eurocentric as a contrast to Eurocentric, but I am not intending to declare a sameness between non-Eurocentric views. It can be fruitful to contrast Eurocentric and non-Eurocentric, with the understanding that there is substantial diversity between and amongst non-Eurocentric views.

[ii] It is important to remember that not all Indigenous people uphold the same view. Throughout this paper I will be considering an example of one traditional Indigenous perspective on the self: the ecocentric conception.

[iii] For an analysis of the colonial view of the person see Coulthard, Glen Sean. *Red Skin White Masks: Rejecting the Colonial Politics of Recognition.* University of Minnesota Press, 2014.

[iv] It is worth emphasising here that there are numerous understandings of the person that are alternative to the independent construal assumed by many Canadian psychologists and psychiatrists; the sociocentric self is one alternative perspective amongst many.

[v] American Psychiatric Association 2013, 20.

[vi] This construal is a colonising one because it comes to dominate and exclude other conceptions of the self.

[vii] Markus and Kitayama 1991, 226.

[viii] By *autonomous* I intend to invoke the idea of a person as self-determining, atomistic, self-sufficient, and essentially independent from others. Other perspectives about autonomy exist, and have been promoted by feminist theorists – for example, the notion of relational autonomy. This is not the notion I am critiquing.

[ix] Markus and Kitayama 1991, 226.

[x] Wakefield 1992, 373.

[xi] Wakefield 1992, 374.

[xii] In certain parts of the world it is 'normal' and even a sign of spiritual elevation if a person hallucinates, while in others such experiences would be considered harmful to the individual (it disrupts the individual's performance, it undermines the control they have over their life since the hallucinations are not voluntarily experienced, and so on). In the former case no disorder is present, while in the latter there is. Hallucinations, then, only qualify as disordered behaviour insofar as they are not species-typical *and* cause the individual harm.

[xiii] American Psychiatric Association 2013, 20, my emphasis.

[xiv] Some would argue the Eurocentric individualistic approach to the person that is perpetrated by the DSM-5 is in fact not effective even for individuals raised with Eurocentric values. Because human beings are inherently social – Aristotle famously declared that "man is a social animal" – disorders in human beings therefore must be understood according to and within a social context. On this account, all human beings are always profoundly and irrevocably influenced by their social environments.

[xv] See p.7-8 for this discussion.

[xvi] Bracken et al. 1995, 3.

[xvii] Bracken et al. 1995, 2.

[xviii] Bracken et al. 1995, 3-4.

[xix] Bracken et al. 1995, 5.

[xx] Kirmayer et al. 2009, 292.

[xxi] Kirmayer et al. 2009, 293.

[xxii] Kirmayer et al. 2009, 293.

[xxiii] Kirmayer et al. 2009, 294.

[xxiv] The claims I make about Syrian beliefs are based in the knowledge that I have gained from my personal experiences with Syrian refugees, as a volunteer interpreter. This is an area that merits much greater attention and research.

[xxv] Markus and Kitayama 1991, 227.

[xxvi] Markus and Kitayama 1991, 227.
[xxvii] Markus and Kitayama 1991, 227.
[xxviii] Bracken et al. 1995, 9.
[xxix] Bracken et al. 1995, 10.
[xxx] Agic et al. 2016, 6.
[xxxi] Agic et al. 2016, 4.
[xxxii] Markus and Kitayama 1991, 227.
[xxxiii] Through my experience as volunteer interpreter, I have witnessed the difficulty that Syrian refugees face in communicating in English. It is important to keep in mind that the availability of English-learning courses in Canada does not necessarily indicate that Syrian refugees will learn English quickly or effectively. In the words of Tara Saberpor, "availability does not necessarily mean accessibility, especially for refugees" (16). Refugees face challenges with respect to accessing information about available services such as language courses, and with navigating transportation to these classes, amongst other factors.
[xxxiv] See https://Améry .canada.ca/en/immigration-refugees-citizenship/services/refugees.html and https://settlement.org/ontario/immigration-citizenship/refugees/after-you-arrive/what-assistance-can-refugees-get-in-canada/ for information on the particular services offered by Canada and Ontario to refugees, respectively.
[xxxv] Markus and Kitayama 1991, 228. Markus and Kitayama say this about Japanese culture.
[xxxvi] Saberpor 2016, 5.
[xxxvii] The articulation of these policies has been informed by my lived experiences with Syrian refugees as well as my reading of Tara Saberpor (2016); The Mental Health Commission of Canada (2016); The Parliamentary Information and Research Service (2013); Marie McKeary's and Bruce Newbold (2010); and The World Health Organisation (WHO).
[xxxviii] Saberpor 2016, 11.
[xxxix] Saberpor 2016, 11.
[xl] Saberpor 2016, 6-7.
[xli] McKeary et al. 2010, 15.
[xlii] Fazel et al. 2005.
[xliii] McKeary and Newbold 2010.
[xliv] Beiser 1993.